

00478

CERTIFICATE OF DEATH

00481

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|---|----------------------------------|---|-------------------------------------|--|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | | | c. LENGTH OF STAY IN 1b 62 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital | | | | d. STREET ADDRESS North Beach | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last Bowen | | | | 4. DATE OF DEATH Month 1 Day 20 Year 1967 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-30-40 | 9. AGE (In years last birthday) 26 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (County & State, or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas McKee | | | | 14. MOTHER'S MAIDEN NAME Mary Ann - - - | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) --- | | 16. SOCIAL SECURITY NO. 578-60-5725 | | 17. INFORMANT Address Donald W. Bowen North Beach, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 199.2 IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-19 , 19 66 , to 1-20 , 19 67 that (I) (we) last saw the deceased alive on 1-20 , 19 67 , and that death occurred at 5:25 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>George J. Weems</i> | | | | 22b. DATE SIGNED Jan. 21, 1967 | | 22c. PHYSICIAN'S NAME (Type) George J. Weems | |
| 22d. ADDRESS Huntingtown, Maryland | | | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Jan. 22, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Friendship Chr. Cemetery | | 23d. LOCATION (City or Town) (County) (State) Friendship, A.A. Co. Md. | |
| 24. FUNERAL DIRECTOR Hutchins Funeral Home | | | | 25a. REC'D BY REGISTRAR DATE JAN 25 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington, D.C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | c. LENGTH OF STAY IN 1b 2 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital | | d. STREET ADDRESS 1820 23rd St., S.E. | |
| 3. NAME OF DECEASED (Type or print) Cecelia Margaret Dekdebrun | | 4. DATE OF DEATH Month 1 Day 10 Year 1967 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-14-02 |
| 9. AGE (In years last birthday) 64 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Patrick Cleary | | 14. MOTHER'S MAIDEN NAME Margaret Kerans | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 115-14-9081 | | 17. INFORMANT Edward Dekdebrun - same - | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Coronary Thrombosis DUE TO (c) Coronary Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 8 , 1967, to Jan. 10 , 1967, that (I) (we) last saw the deceased alive on Jan. 10 , 1967, and that death occurred at 1028 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Osman Z. Ersoy | | 22b. DATE SIGNED 1-11-67 | |
| 22c. PHYSICIAN'S NAME (Type) Osman Z. Ersoy | | 22d. ADDRESS Prince Frederick, Maryland | |
| 23a. BURIAL CREMATION REMOVAL (Specify) Burial | 23b. DATE THEREOF Jan. 14, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Eastern Memorial Gardens | 23d. LOCATION (City or Town) (County) (State) Princk, Calvert Md. |
| 24. FUNERAL DIRECTOR A.A. McKee & Son, Port Republic, Md. | | 25a. REC'D BY REGISTRAR DATE JAN 13 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other disposal, and in any event, within 72 hours after death.

00482

RECEIVED OF DEATH

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On 10/10/10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------------------|--|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 00480 | | | | | | | | | | | |
| CERTIFICATE OF DEATH Items 8 & 9 Film G 385 | | | | | | | | | | | |
| Item 9 Film G384 1/10/67 mb 1/24/67 jml 00483 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Calvert</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dunkirk</u> | | | | c. LENGTH OF STAY IN 1b | | | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dunkirk</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Maria Estelle Ford</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1967</u> | | | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1874</u> | | 9. AGE (In years last birthday) <u>88</u> | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Md. (92)</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>John Cortes</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Cornelia Hankins</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. <u>422-1</u> | | | | 17. INFORMANT <u>Skp Ford, Dunkirk Md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular disease</u> 422.1 DUE TO <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Age</u> (c) <u>Age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1967</u> to <u>June 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 11, 1967</u> , and that death occurred at <u>130 hrs</u> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | 22b. DATE SIGNED <u>June 3, 1967</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u> | | | | 22d. ADDRESS <u>Dunkirk Md</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-7-67</u> | | | | 23b. DATE THEREOF | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Coopers C.C.</u> | | | |
| 23d. LOCATION (City, town or county) (State) <u>Dunkirk Cal. Md.</u> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Linkney E. Sewell - Prince Fred.</u> | | | | 25a. REC'D BY REGISTRAR <u>[Signature]</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

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CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick D.O.A. | | | | c. LENGTH OF STAY IN 1b Port Republic | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital | | | | d. STREET ADDRESS — | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Robert Anthony Harkness | | | | 4. DATE OF DEATH Month Day Year 1 18 19 67 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-18-07 | 9. AGE (In years last birthday) yrs. 59 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mortician | | 10b. KIND OF BUSINESS OR INDUSTRY Funeral Home | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Arthur A. Harkness | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Parran | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-14-7388 | | 17. INFORMANT Address Thelma W. Harkness, Port Republic, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crown Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pericardial Crown Thrombosis DUE TO (c) 16 weeks | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (This hospital) attended the deceased from Jan 18 , 19 67 , to Jan 18 , 19 67 , that (I) (we) last saw the deceased alive on Jan 18 , 19 67 , and that death occurred at 11:34 M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE R. DE VILLARREAL | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 1-18-67 | |
| 22c. PHYSICIAN'S NAME (Type) R. DE VILLARREAL | | | | 22d. ADDRESS St. Thomas | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Jan. 21, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery | | 23d. LOCATION (City or Town) (County) (State) Port Republic Calvert, Md. | |
| 24. FUNERAL DIRECTOR G.A. Harkness & Son, Port Republic, Md. | | 25a. REC'D BY REGISTRAR DATE JAN 23 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

00482

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Hillside</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert County Hospital</u> | | d. STREET ADDRESS <u>1516 54th Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Howard Matthew Herbert</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-26-42</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>25</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Howard Herbert</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Eliz. Morgan</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-48-3664</u> | |
| 17. INFORMANT <u>Rose Ellen Herbert</u> | | Address <u>same as \$ 2 above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>8234</u> IMMEDIATE CAUSE (a) <u>Fractured Skull</u> DUE TO (b) <u>Broken leg</u> DUE TO (c) <u>Wound from gunshot</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Auto accident</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto ran off road</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:30</u> <u>1</u> <u>27</u> <u>1967</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u> | 20f. (City or town) <u>Owing</u> (County) <u>Calvert</u> (State) <u>Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>H. W. Ward</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Owing</u> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>1/30/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Morganza, St. Mary's Md.</u> | |
| 24. FUNERAL DIRECTOR <u>W. Clarke Mattina</u> | | 25a. REC'D BY REGISTRAR <u>Leonardtown, Md.</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>FEB 1 1967</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00483

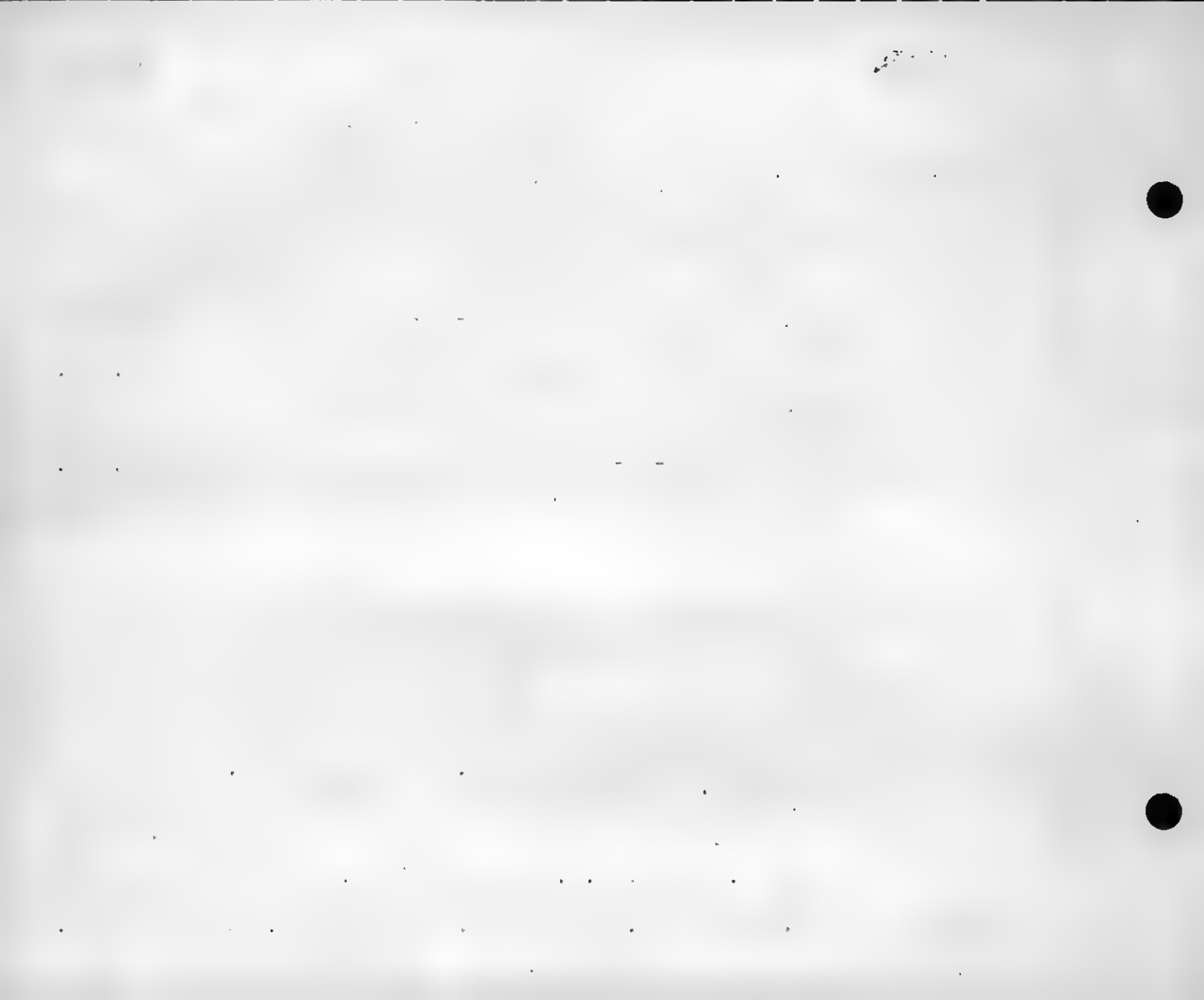
CERTIFICATE OF DEATH

00486

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|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | c. LENGTH OF STAY IN lb 2 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings | | d. STREET ADDRESS Calvert County Hospital | |
| 3. NAME OF DECEASED (Type or print) First Roxie Middle Belle Last Hill | | 4. DATE OF DEATH Month 1 Day 19 Year 19 67 | |
| 5. SEX female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-24-90 |
| 9. AGE (In years last birthday) yrs 76 | | 10. IF UNDER 1 YEAR Months 19 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10b. KIND OF BUSINESS OR INDUSTRY Cashier - Amusement | |
| 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Wesley Sturdivant | | 14. MOTHER'S MAIDEN NAME Hattie Brown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown | | 16. SOCIAL SECURITY NO 213-16-9732 | |
| 17. INFORMANT Myrtle Brooks | | Address North Beach, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 17, 19 67 , to Jan. 19 19 67 that (I) (we) last saw the deceased alive on Jan. 19, 1967 , and that death occurred at 11:15 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE George J. Weems, M.D. | | 22b. DATE SIGNED Jan. 21, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) George J. Weems, M.D. | | 22d. ADDRESS Owings, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Jan. 23, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Chr. Cemetery | 23d. LOCATION (City or Town) (County) (State) Owings, Calvert Md. |
| 24. FUNERAL DIRECTOR Hutchins Funeral Home | | ADDRESS Owings, Maryland | |
| 25a. REC'D BY REGISTRAR DATE JAN 25 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

00484

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00487

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH a COUNTY <i>Cecil</i> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <i>Md</i> b. COUNTY <i>Cecil</i> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hamlet</i> | | c LENGTH OF STAY IN 1b <i>1 week</i> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d STREET ADDRESS | |
| 3 NAME OF DECEASED (Type or print) <i>Carol</i> First Middle Last <i>Halliday</i> | | 4 DATE OF DEATH Month <i>30</i> Day <i>1967</i> Year <i>1967</i> | |
| 5 SEX <i>M</i> | 6 COLOR OR RACE <i>W</i> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <i>Sept 6 1907</i> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>farmer</i> | | 10b KIND OF BUSINESS OR INDUSTRY <i>W</i> | 9 AGE (In years last birthday) <i>59</i> yrs |
| 11 BIRTHPLACE (State or foreign country) <i>Md</i> | | 12 CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13 FATHER'S NAME <i>Joseph Halliday</i> | | 14 MOTHER'S MAIDEN NAME <i>Annie Willy</i> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO <i>578-091648</i> | 17 INFORMANT <i>Annie Boogie Sunderland</i> Address |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary failure</i> 78 x 4 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Decomposed</i> | | | 9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Heart failure</i> | |
| 20c TIME OF INJURY Month, Day, Year Hour <i>7</i> pm <i>11/30 1967</i> | 20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Home</i> | 20f (City or town) <i>Hamlet</i> (County) <i>Cecil</i> (State) <i>Md</i> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>H. L. Ward</i> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) <i>1150/67</i> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | 23b DATE THEREOF <i>2-4-67</i> | 23c NAME OF CEMETERY OR CREMATORY <i>St. Edmonds C.C</i> | 23d LOCATION (City or Town) <i>Sunderland</i> (County) <i>Cal.</i> (State) <i>Md</i> |
| 24. FUNERAL DIRECTOR <i>Pinkey E. Sawell</i> | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | |
| ADDRESS <i>Prince Fred, Md</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |
| DATE <i>FEB 2 1967</i> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
3
FOR STATE
HEALTH DEPT.

00485

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00485

| | | | |
|--|---------------------------|---|------------------------------------|
| 1 PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if not at an institution) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| 3 NAME OF DECEASED (Type or print) <u>Francis</u> First Middle Last | | 4 DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1967</u> | |
| 5 SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 27 '91</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles McVerney</u> | | 14. MOTHER'S MAIDEN NAME <u>Helene Henrich</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> | | 16. SOCIAL SECURITY NO <u>3</u> | |
| 17. INFORMANT <u>Phy. Leon C. Ward</u> Address <u>3307 Fairland Rd</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1804.7</u> DUE TO <u>Cardiac fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Blunt force</u> DUE TO <u>Blunt force</u> (c) <u>Blunt force</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Found dead in bed in her home</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in bed in her home</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>1/10/67</u> Hour <u>11</u> AM <u>PM</u> | | 20d. INJURY OCCURRED Where <input type="checkbox"/> Nat'l <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Port Republic</u> (County) <u>Calvert</u> (State) <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>H. W. Ward</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>H. W. Ward</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or town) (County) (State) | |
| 24. FUNERAL DIRECTOR <u>A. A. Harkness Son, Port Republic, Maryland</u> | | 25a. RECD BY REGISTRAR <u>Charles Judge</u> | |
| | | 25b. REGISTRAR'S SIGNATURE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00486

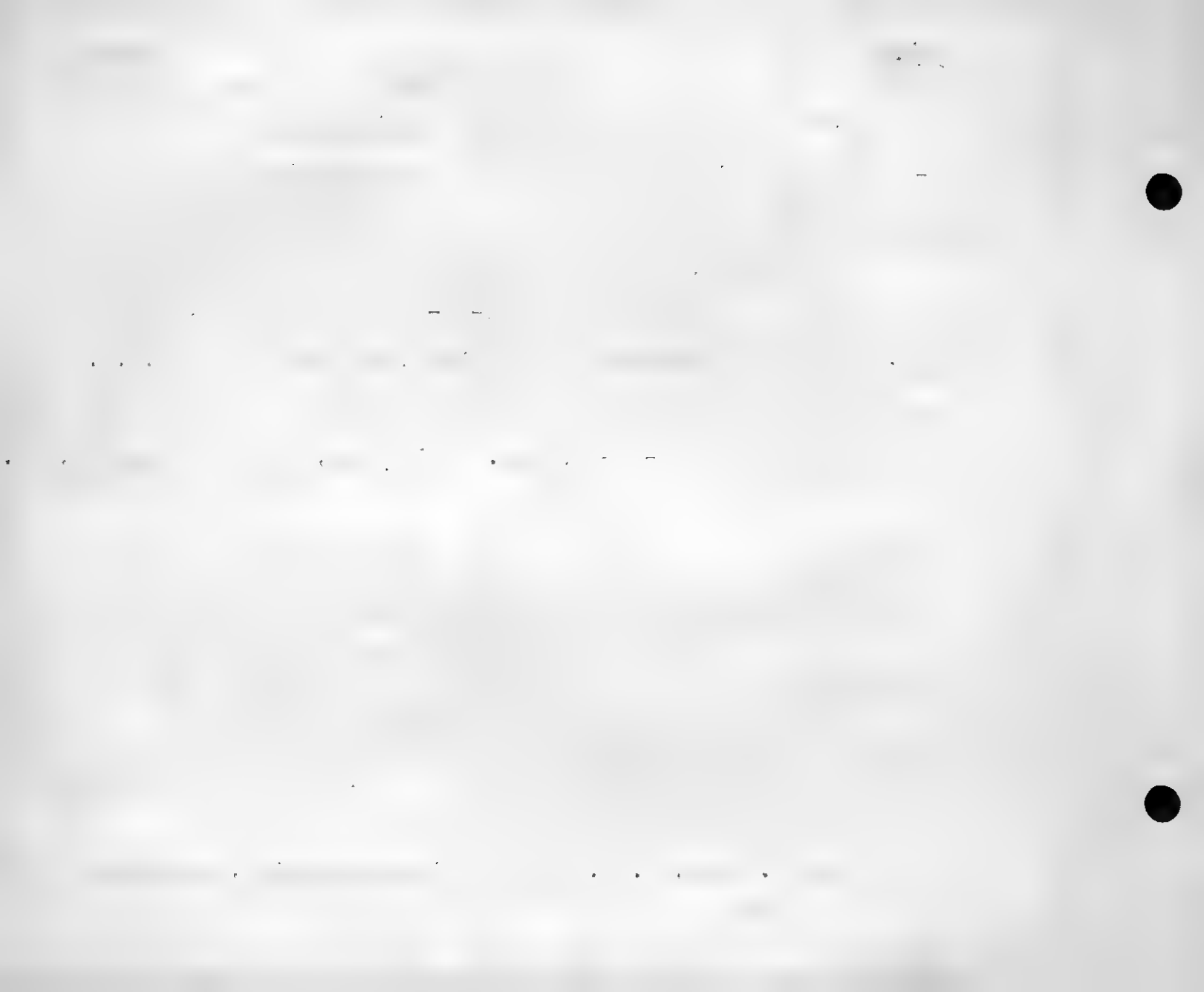
CERTIFICATE OF DEATH

00489

| | | | |
|--|-----------------|---|-----------------|
| 1 PLACE OF DEATH a COUNTY | | 2 USUAL RESIDENCE (If deceased lived, if institution Residence before admission) a. STATE | |
| Calvert MARYLAND | | Maryland b COUNTY Calvert | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c LENGTH OF STAY IN 1b | |
| Rural-Prince Frederick | | 49 days | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d STREET ADDRESS | |
| Calvert County | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | |
| First Middle Last Charles David Peck | | Month Day Year January 14 19 67 | |
| 5 SEX | 6 COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8 DATE OF BIRTH |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 1-21-11 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| Restaurant Owner | | Restaurant | |
| 13 FATHER'S NAME | | 14 MOTHER'S MAIDEN NAME | |
| George Peck | | Marie Johnson | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO. | |
| No | | 219-48-0663 | |
| 17 INFORMANT | | Address | |
| Mrs. Marie Peck, Prince Frederick, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 10001 Circumstances of lung (bronchopneumonia) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 2, 1966, to Jan 14, 1967, that (I) (we) last saw the deceased alive on 1/14 1967, and that death occurred at 9:27 A.M. from causes and on the date stated above. | | | |
| 22a SIGNATURE Page C. Jett, M. D. | | 22b DATE SIGNED | |
| 22c PHYSICIAN'S NAME (Type) | | 22d ADDRESS | |
| Prince Frederick, Maryland | | | |
| 23a BURIAL CREMATION REMOVAL (Specify) | | 23b DATE | |
| Removal to Prince Frederick | | 1/17/67 | |
| 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | |
| Cemetery | | Hancock N.Y. | |
| 24 FUNERAL DIRECTOR | | 25 REC'D BY REGISTRAR | |
| A.A. Harkness, Port Republic, Md. | | DATE JAN 17 1967 | |
| 25b REGISTRAR'S SIGNATURE | | | |
| Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, upon any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--|--|---|--|--|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 00487 CERTIFICATE OF DEATH 00488 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North Beach | | | | c. LENGTH OF STAY IN 1b 5 years | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North Beach | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | | d. STREET ADDRESS 3rd St. & Louisville Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ELSIE | | | First Middle Last MAE PRESNELL | | | 4. DATE OF DEATH January 3 1967 | | | Month Day Year | | |
| 5. SEX Female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 18, 1874 | | 9. AGE (In years last birthday) 92 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Agent | | | | 10b. KIND OF BUSINESS OR INDUSTRY Pa. R.R. (retired) | | 11. BIRTHPLACE (County & State, or foreign country) Staunton, Indiana | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Joseph Carmichael | | | | | | 14. MOTHER'S MAIDEN NAME Leah Boor | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - - - | | | | 16. SOCIAL SECURITY NO. - - - - - | | 17. INFORMANT Paul Presnell, 3rd St. & Louisville Ave. North Beach, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) old age 714 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1962 , 19, to 1966 , 19, that (I) (we) last saw the deceased alive on 12-27-1966 , and that death occurred at 2A-M , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Issam F. Damalouji | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED Jan. 3, 1967 | | |
| 22c. PHYSICIAN'S NAME (Type) Issam F. Damalouji | | | | | | 22d. ADDRESS Prince Frederick, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF Jan. 7, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Highland Lawn Cemetery | | | 23d. LOCATION (City, town or county) (State) Vigo Co., Indiana | | | |
| 24. FUNERAL DIRECTOR Hutchins Funeral Home | | | | | | ADDRESS Owings, Maryland | | | 25a. REC'D BY REGISTRAR DATE Jan 9 1967 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE William J. Judge | | | | | |

00488

CERTIFICATE OF DEATH

00493

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|---|
| 1 PLACE OF DEATH a. COUNTY Calvert MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Calvert | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | c. LENGTH OF STAY IN 1b 10 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital | | d. STREET ADDRESS Dowell | |
| 3 NAME OF DECEASED (Type or print) Benjamin Wallace Purvey | | 4 DATE OF DEATH Month 1 Day 24 Year 19 67 | |
| 5 SEX Male | 6. COLOR OR RACE Negro | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-1-10 |
| 9 AGE (In years last birthday) yrs 56 | | 10. IF UNDER 1 YEAR Months 24 Days 19 Hours 67 Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11 BIRTHPLACE (County & State, or foreign country) U.S.A. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Benjamin Purvey | | 14. MOTHER'S MAIDEN NAME Rita Offer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. 218-14-3496 | |
| 17. INFORMANT Beatrice B. Purvey Dowell | | Address Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 446X IMMEDIATE CAUSE (a) Uremia DUE TO (b) neptroclasis DUE TO (c) without structure | | INTERVAL BETWEEN ONSET AND DEATH (| |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from Jan. 14, 1967 , to Jan. 24, 1967 , that (I) (we) lost the deceased alive on Jan. 24, 1967 , and that death occurred at 2:00 PM , from causes and on the date stated above | | | |
| 22a. SIGNATURE [Signature] | | 22b. DATE SIGNED 1-24-67 | |
| 22c. PHYSICIAN'S NAME (Type) Roberto de Villarreal, M.D. | | 22d. ADDRESS St. Leonard, Maryland | |
| 23a. (BURIAL, CREMATION, REMOVAL) (Specify) 1-28-67 | 23b. DATE THEREOF 1-28-67 | 23c. NAME OF CEMETERY OR CREMATORY St. John's Church Cem. | 23d. LOCATION (City or Town) (County) (State) Calvert Co. Md. |
| 24. FUNERAL DIRECTOR Prince Frederick, Md. | | 25a. REC'D BY REGISTRAR DATE: 3-3-1967 | 25b. REGISTRAR'S SIGNATURE [Signature] |



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00489

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if not last on Residence before death on) a. STATE <u>Md</u> b. COUNTY <u>1</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick Frederick P.O. A</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4311 Lot 75 Upper Marlboro</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert County Hospital</u> | | d. STREET ADDRESS | |
| 3 NAME OF DECEASED (Type of death) <u>FRANCIS Kathleen</u> Middle | | 4 DATE OF DEATH Month <u>Jan</u> Day <u>27</u> Year <u>1967</u> | |
| 5 SEX <u>F</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Dec 11, 1936</u> |
| 9 AGE (In years last birthday) <u>30</u> yrs | | F UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper at home</u> | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Robert Francis Raymond</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna E Williams</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u> | | 16 SOC. SEC. NO. <u>299-44-7640</u> | |
| 17 INFORMANT <u>Maria E Farmer</u> | | Address <u>Same as (2C)</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO (b) <u>Broken leg</u> DUE TO (c) <u>Many lacerations about head & jaw</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto Accident</u> | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year <u>1230 am Jan 27 1967</u> | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc) | | 20f (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>H. W. Ward</u> | | M.D. | |
| EXAMINER'S NAME (Type) | | 22. DATE SIGNED <u>1/27/67</u> | |
| 23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | 23b DATE THEREOF <u>1-31-1967</u> | |
| 23c NAME OF CEMETERY OR CREMATORY <u>Wash Natl Cem</u> | | 23d LOCAT ON (City or town) (County) (State) <u>Southland Md.</u> | |
| 24 FUNERAL DIRECTOR <u>W W Chambers Co</u> | | ADDRESS <u>517-11th St SE Wash DC</u> | |
| 25a REC'D BY REGISTRAR DATE <u>FEB 2 1967</u> | | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



00490

CERTIFICATE OF DEATH

00493

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Calvert MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunderland | |
| c. LENGTH OF STAY IN 1b 12 days | | d. STREET ADDRESS Calvert County Hospital | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary Esther Robinson | | 4 DATE OF DEATH Month Day Year January 22 19 67 | |
| 5. SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 2-6-98 |
| 9 AGE (In years last birthday) 68 yrs | | 10 IF UNDER 1 YEAR Months Days Hours Min | 11 IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles F. Stevens | | 14. MOTHER'S MAIDEN NAME Margaret Childs | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) — | | 16 SOCIAL SECURITY NO. 579-40-0138 | |
| 17. INFORMANT Anne C. Stertz, Sunderland, Maryland | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 420.1 IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 8, 19 67 to Jan. 22, 1967 , that (I) (we) last saw the deceased alive on Jan. 22 1967 , and that death occurred at 1:00 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Issam El Damalouji | | 22b. DATE SIGNED Jan 27 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Issam El Damalouji, M.D. | | 22d. ADDRESS Prince Frederick, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 1/25/67 | 23c. NAME OF CEMETERY OR CREMATORY Central Cemetery | 23d. LOCATION (City or Town) (County) (State) Barstow Calvert Md. |
| 24. FUNERAL DIRECTOR Hutchins Funeral Home | | 25a. REC'D BY REGISTRAR JAN 27 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

CERTIFICATE OF DEATH

00491

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|---|
| 1 PLACE OF DEATH a. COUNTY CALVERT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY AA Co | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt HARMONY | | c. LENGTH OF STAY IN 1b Lothian | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PADGETT NURSING Home | | d. STREET ADDRESS Lothian | |
| 3. NAME OF DECEASED (Type or print) ANNIE V First Middle Last | | 4. DATE OF DEATH Month January Day 4 Year 1967 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/9/1880 |
| 9. AGE (In years last birthday) 86 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 11a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME | |
| 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO | | 17. INFORMANT Lollie L. Love Address 602 N. KENYON AVE. Baltimore MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 304 (b) Generalized arteriosclerosis (c) | | INTERVAL BETWEEN ONSET AND DEATH years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease with Auricular Fibrillation | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no accident | |
| 21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 21f. (City or town) (County) (State) | | 21g. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/17/66 , 19 to 1/1/67 , 19, that (I) (we) last saw the deceased alive on 1/1/67 , 19, and that death occurred at 10:30 AM on 1/1/67 , 19, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Charles H. Wirth M.D. | | 22b. DATE SIGNED 1/4/67 | |
| 22c. PHYSICIAN'S NAME (Type) Charles H. Wirth, M.D. | | 22d. ADDRESS Lothian, Maryland 20820 | |
| 23a. BURIAL, CREMATION, REMOVA (Specify) BURIAL | 23b. DATE THEREOF 1-6-67 | 23c. NAME OF CEMETERY OR CREMATORY St James | 23d. LOCATION (City or town) (County) (State) Traceys Landing, Md |
| 24. FUNERAL DIRECTOR Thomas Handley, Galesville, Md | | 25a. REC'D BY REGISTRAR DATE JAN 11 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

00492

CERTIFICATE OF DEATH

00495

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|--|---|
| 1 PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Padgetts Nursing Home</u> | | d. STREET ADDRESS <u>Rt 2 Box 88B</u> | |
| 3 NAME OF DECEASED (Type or print) <u>Violet</u> First <u>Olivia</u> Middle <u>Stallings</u> Last | | 4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1967</u> | |
| 5 SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Mar. 14, 1894</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9 AGE (In years last birthday) <u>72</u> yrs |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Edgewater, Md.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Thomas Walker</u> | | 14. MOTHER'S MAIDEN NAME <u>Amanda Lee</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>219-38-5601</u> | |
| 17. INFORMANT <u>A. Earl Stallings - same as #2 above</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>1/1/67</u> , 19____, that (I) (we) last saw the deceased alive on <u>1/1/67</u> , 19____, and that death occurred at <u>4:40 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Charles H. Wirth MD</u> | | 22b. DATE SIGNED <u>1/2/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Charles H. Wirth MD</u> | | 22d. ADDRESS <u>Lothian, AA Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>1/5/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Lothian, AA Md.</u> | |
| 24 FUNERAL DIRECTOR <u>Beverley E. Hopping</u> <u>Hopping Funeral Home - Annapolis, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>JAN 6 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

00493

CERTIFICATE OF DEATH

00496

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Calvert MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | c. LENGTH OF STAY IN TB 93 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital | | e. STREET ADDRESS Box 143 | |
| 3. NAME OF DECEASED (Type or print) First Lois Middle Ella Last Summey | | 4 DATE OF DEATH Month 1 Day 13 Year 19 67 | |
| 5 SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-7-15 |
| 9 AGE (In years last birthday) 52 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Drug Store | |
| 11. BIRTHPLACE (County & State, or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Ralph Barnes | | 14 MOTHER'S MAIDEN NAME Ella Case | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - | | 16. SOCIAL SECURITY NO. 579-24-5115 | |
| 17 INFORMANT Roy H. Summey | | Address North Beach, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory collapse DUE TO (b) Generalized Cancer - DUE TO (c) intracerebral cancer | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 12, 1966 , to Jan. 13 1967 , that (I) (we) last saw the deceased alive on Jan. 13 1967 , and that death occurred at 1100a.m. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Osman Z. Ersoy | | 22b. DATE SIGNED 1-13-67 | |
| 22c. PHYSICIAN'S NAME (Type) Osman Z. Ersoy | | 22d. ADDRESS Prince Frederick, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Jan. 15, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Sou. Memorial Gardens | 23d. LOCATION (City or Town) (County) (State) Dunkirk, Calvert Co. Md. |
| 24. FUNERAL DIRECTOR Hutchins Funeral Home Owings, Md. | | 25a. REC'D BY REGISTRAR Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE JAN 17 1967 | |

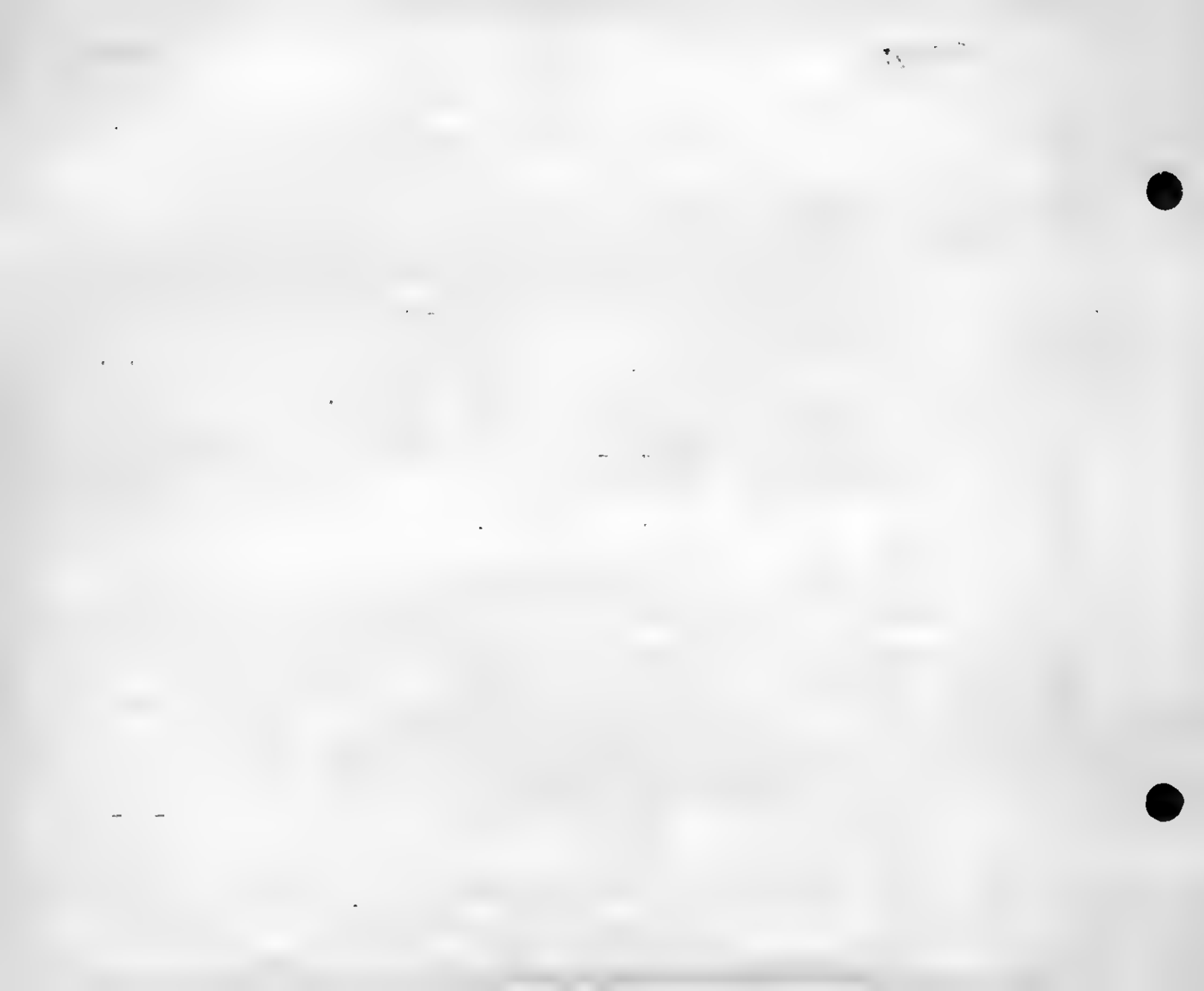
00494

CERTIFICATE OF DEATH

00497

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institut an- Residence before admission) a. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | c. LENGTH OF STAY IN TB 5 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lusby | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital | | | | d. STREET ADDRESS — | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Alan Middle Claude Last Turner | | | | 4. DATE OF DEATH Month 1 Day 18 Year 19 67 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-16-89 | 9. AGE (In years last birthday) 77 yrs | 10. IF UNDER 1 YEAR Months 1 Days 18 | | 11. IF UNDER 24 HRS Hours 19 Min 67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Farmer | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME John Turner | | | | 14. MOTHER'S MAIDEN NAME Eloise S. Wilson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-34-2130 | | 17. INFORMANT Mary Broome Turner Lusby, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis DUE TO Bright's disease? (b) Heart failure DUE TO Heart failure (c) Heart failure | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1/10 , 19 67 , to 1/18 , 19 67 that (I) (we) lost saw the deceased alive on Jan 18 1967 and that death occurred at 10:30am , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE R. De Vill Parker | | | | 22b. DATE SIGNED 1-18-67 | | 22c. PHYSICIAN'S NAME (Type) R. De Vill Parker | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Jan 20, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Middlemen Chapel Cmts | | 23d. LOCATION (City or Town) (County) (State) Lusby Calvert Md. | |
| 24. FUNERAL DIRECTOR A.G. & Son | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE JAN 23 1967 | |



FOR STATE
HEALTH DEPT.

00495

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00498

| | | | | | | | |
|--|----------------------------------|---|--|--|--|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick - rural | | | | c. LENGTH OF STAY IN lb 4 weeks | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Co. Hospital | | | | d. STREET ADDRESS Chesapeake Beach Road - Owings | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Julius Russell Ward | | | | 4. DATE OF DEATH Month Day Year 1 21 19 67 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 15, 1906 | | 9. AGE (In years lost birthday) yrs 60 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent | | 10b. KIND OF BUSINESS OR INDUSTRY Life Insurance | | 11. BIRTHPLACE (State or foreign country) Calvert Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME J. Horace Ward | | | | 14. MOTHER'S MAIDEN NAME Margaret Norfolk | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - | | 16. SOCIAL SECURITY NO. 214-05-0956 | | 17. INFORMANT Mrs. Russell Ward, Chesapeake Beach Road Owings, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 465X IMMEDIATE CAUSE (a) Massive pulmonary embolism complicating fracture of left tibia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - due to (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Auto accident in snow storm during the night | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell in snow storm | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:30 p.m. 12 24 19 66 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chanyville | | 20f. (City or town) (County) (State) Calvert Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) | | | |
| 22. DATE SIGNED 1/22/67 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Jan 25, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Huntingtown Cemetery | | 23d. LOCATION (City or Town) (County) (State) Huntingtown, Calvert Md. | |
| 24. FUNERAL DIRECTOR Hutchins Funeral Home | | | | ADDRESS Owings, Maryland | | 25a. REC'D BY REGISTRAR JAN 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

59

3

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00496

CERTIFICATE OF DEATH

00499

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b 84 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willows Chesapeake Beach, Maryland d. STREET ADDRESS 04-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Pauline Harrell Whittaker | | 4. DATE OF DEATH Month 1 Day 26 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-2-10 |
| 9. AGE (In years last birthday) yrs. 56 | | 10. IF UNDER 1 YEAR Months Days Hours Min. 1967 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY North Carolina | |
| 11. BIRTHPLACE (County & State, or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME George Harrell | | 14. MOTHER'S MAIDEN NAME Sally Parker | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - - | | 16. SOCIAL SECURITY NO. 578-12-1380 | |
| 17. INFORMANT William Whittaker | | Address Chesapeake Beach, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis. DUE TO (c) metastasis. DUE TO INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 11-5 , 19 66 , to 1-26 , 19 67 that (I) (we) last saw the deceased alive on Jan. 26 19 67 , and that death occurred at 3:40 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Issam El Damalouji, M.D. | | 22b. DATE SIGNED 1-26-67 | |
| 22c. PHYSICIAN'S NAME (Type) Issam El Damalouji, M.D. | | 22d. ADDRESS Prince Frederick, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Jan. 29, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | 23d. LOCATION (City or Town) (County) (State) Portsmouth, Va. |
| 24. FUNERAL DIRECTOR Hutchins Funeral Home | | 25a. REC'D BY REGISTRAR owings, Maryland | |
| 25b. REGISTRAR'S SIGNATURE Charles Jones | | 25c. DATE FEB 1 1967 | |

00430

STATE OF TEXAS

00430

IN SENATE,
January 22, 1907.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1906.

THE COMMISSIONER OF THE LAND OFFICE,
HONORABLE SENATOR,
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF YOUR REPORT,
AND TO RETURN TO YOU THE ORIGINAL OF THE SAME.
Yours very respectfully,
J. W. HARRIS,
COMMISSIONER OF THE LAND OFFICE.

Jan. 22, 1907
Honorable Senator,
Austin, Texas.